

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 57 Portland Place,
HAMILTON, Lanarkshire, ML3 7LA

Pharmacy reference: 1042552

Type of pharmacy: Community

Date of inspection: 21/05/2024

Pharmacy context

This is a community pharmacy in Hamilton, Glasgow. Its main activities are dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides NHS services such as NHS Pharmacy First. And it delivers medicines to people in their homes.

Overall inspection outcome

✓ **Standards met**

Required Action: None

Follow this link to [find out what the inspections possible outcomes mean](#)

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy's written procedures help manage risk to allow team members to deliver services safely and effectively. Team members record mistakes made during the dispensing process and make changes to help prevent the same or a similar mistake occurring. They keep the necessary records required by law and they keep people's private information secure. They have the necessary training and resources to respond appropriately to concerns for the welfare of vulnerable people accessing the pharmacy's services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to manage risks and guide team members to work safely and effectively. These included SOPs about the responsible pharmacist (RP), controlled drug (CD) management and dispensing procedures. A sample of SOPs seen showed they had been reviewed in the past two years and were due to be reviewed in 2025. Team members accessed the SOPs online and completed electronic declarations to confirm they understood and would comply with them. And they retained certificates as evidence of having signed the declarations. The accuracy checking pharmacy technician (ACPT) had discussed and agreed with the RP what medicines they felt comfortable checking, and this did not include CDs.

The pharmacy recorded mistakes identified and corrected during the dispensing process, known as near misses. The person who was responsible for making the mistake recorded the details about it. Team members discussed the errors informally and reviewed the data produced from near misses to identify any trends. And all team members contributed ideas to help prevent the same or a similar mistake happening again. For example, they had separated two different strengths of levothyroxine which had similar packaging from each other in the drawers where they were kept. And the pharmacist refreshed the team's knowledge of inhalers, including the difference between CFC-free inhalers and dry powder inhalers. The pharmacy completed reports for mistakes that were not identified until after a person had received their medicines, known as dispensing incidents. These were reported electronically and were shared with the company's head office team. The pharmacy had a complaints procedure which was displayed in the retail area of the pharmacy. Team members aimed to resolve any complaints or concerns informally. If they were unable to resolve the complaint, they escalated it to the company's head office. Team members reacted to feedback provided by people accessing the pharmacy's services. They had ordered chairs in response to feedback that there was not enough seating for those waiting for their prescriptions or while waiting to speak to the pharmacist.

The pharmacy had current professional indemnity insurance. Team members knew which tasks could and could not take place in the absence of the RP. The RP notice was prominently displayed in the retail area and reflected the correct details of the RP on duty. The RP record was completed correctly with some minor omissions of the time the RP ceased duty. The pharmacy recorded the receipt and supply of its CDs. The entries checked were in order, with minor omissions of the wholesaler address for the receipt of CDs. Team members checked the physical stock levels of medicines matched those in the CD register weekly. Records of patient-returned CDs were captured upon receipt and their destruction was completed and witnessed by the pharmacist and a team member. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were kept providing an audit trail. It kept complete records for supplies of medicines made against private prescriptions and retained the

corresponding prescriptions.

Team members were aware of their responsibility to protect people's private information. They received annual training about information governance and General Data Protection Regulation. Team members had completed their training in the past two months. They separated and shredded confidential information on site. The pharmacy displayed a company privacy notice and NHS Scotland Pharmacy First privacy notice in the retail area informing people of how their private data was used. Team members received annual training about safeguarding. And they had a safeguarding policy and operational guidance to refer to if needed. Team members, including the delivery driver, knew to refer any concerns to the pharmacist. The pharmacist was registered with the protecting vulnerable groups scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably qualified or in training team members to help deliver its services safely. Team members complete ongoing training to help develop their skills and knowledge. They ask appropriate questions and give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

The pharmacy team at the time of the inspection included a pharmacist who was the RP and pharmacy manager. They were supported by four dispensers, one of whom was a trainee. An additional two dispensers and an ACPT were not present during the inspection. The pharmacy had a delivery driver who worked across other pharmacies in the company. Team members had either completed accredited qualification training or were completing accredited qualification training for their roles. They received regular updated training via a company online portal. And all team members had recently been trained to provide a new service to dispense medicines as individual doses to help people take their medicines correctly. The pharmacist explained the pharmacy was currently completing a trial period where team members practised processing the prescriptions for the service. And the accuracy of data input on the system was assessed by an ACPT experienced in the service. The pharmacist had read and signed patient group directions to allow them to treat conditions such as urinary tract infections and skin infections under the NHS Pharmacy First service.

There was an open and honest culture amongst the team, and they were observed supporting each other to complete the workload. Team members felt comfortable to raise professional concerns with the pharmacist manager, area lead or head office if necessary. And the company had a whistleblowing policy for team members to refer to. Annual leave was planned so contingency plans could be made. Part-time team members could increase their hours or team members from other pharmacies in the company supported periods of absence if required. The pharmacist manager's absence was supported by relief pharmacists within the company. The company had a performance review process for its team members, but they had not yet received this as the pharmacy had been acquired less than a year previously by the company. Team members received daily communications from the company's head office with information for both pharmacy and retail operations. They were set targets by the company for dispensing activities and pharmacy services, but team members did not feel under pressure to achieve them. They were currently achieving them comfortably.

Team members asked appropriate questions when selling medicines over the counter and were observed referring to the pharmacist for assistance if needed. They knew to be vigilant about repeated requests for medicines liable to misuse, for example medicines containing codeine. Team members, including the pharmacist, had supportive conversations with people and referred them to their GP if necessary.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are secure and suitable for the services it provides. It has appropriate facilities where people can have private conversations with team members.

Inspector's evidence

The pharmacy had a retail area that portrayed a professional appearance. The dispensary was positioned behind the medicines counter. The medicines counter provided a barrier which helped prevent unauthorised access to the dispensary and provided privacy for dispensing activities to take place. The dispensary was small and team members made good use of the limited space. Medicines were stored neatly on shelves and in drawers. There were separate benches for the completion of different tasks. And the pharmacist's checking bench was positioned to allow effective supervision of the dispensary and medicines counter. An area to the rear was used for storage of dispensed medicines. And it had a separate room for team member's breaks. Team members ensured the dispensary was cleaned according to a rota which was up to date. The dispensary had a sink which currently provided only cold water. There was a separate sink in the room used for team member's breaks that provided hot and cold water. And clean toilet facilities provided separate hot and cold water for handwashing.

The pharmacy had a soundproofed consultation room which allowed people to have private conversations with team members and access services. It had a desk, chairs, a sink and a computer. The room was small and there were some boxes stored in the room which reduced the available space. Lighting throughout provided good visibility and the temperature was comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy manages the delivery of its services well. Team members provide people with the necessary information to take their medicines safely. They obtain medicines from recognised sources, and they complete checks on medicines to ensure they remain fit for supply. They know how to respond to alerts about the safety of medicines but do not always keep evidence to show they action the alerts accordingly.

Inspector's evidence

The pharmacy was accessed from the street via a step. Team members had requested maintenance install a handrail to help people when accessing the pharmacy. There was a bell at the front door for people to alert team members if they had difficulty accessing the pharmacy. Team members had good relationships with the people who accessed the pharmacy's services, and provided people with additional assistance, for example if they had hearing difficulties.

Team members used baskets to keep people's prescriptions and medicines together and prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members highlighted the inclusion of a CD, fridge line or if the pharmacist wanted to speak a person when their medicines were handed out. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. Team members provided people with an owing slip if they were unable to produce the full quantity of medicine prescribed. They were observed making suitable checks when handing out medicines to people to ensure they were given to the correct person.

The pharmacy provided medicines as part of a substance misuse service. Team members prepared the doses ahead of them being required by people. The pharmacy had a delivery service, taking medicines to people in their homes. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery, asking them to contact the pharmacy. Medicines that could not be delivered were returned to the pharmacy. Team members used a centralised pharmacy in the company, known as the hub pharmacy, to dispense some of its prescriptions. The pharmacist completed the clinical and data accuracy check at the pharmacy before transferring the details of the prescriptions electronically to the hub pharmacy. The hub pharmacy delivered the completed medicines back to the pharmacy. And team members checked that all medicines were present before handing out to people. If a medicine was not available, team members were alerted via a report, and they completed the prescription in the pharmacy or produced an owing if the medicine wasn't available.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicine effectively. Team members ordered the prescriptions two weeks in advance to allow time to resolve any queries. Each person had a medication record that detailed the medicines taken and the dosage times. Any changes to people's medication were communicated from their GP. The pharmacist annotated the person's medication record after they completed a clinical check. Team members provided descriptions of the medicines in the pack and provided patient information leaflets monthly so people had the necessary information to take their medicines safely.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored behind the medicines counter which helped ensure the sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines and records showed this was up to date. Medicines that were going out of date in the next few months were highlighted for use first. A random selection of approximately 15 medicines found some packs of the same medicine were out of date and these were removed during the inspection. The pharmacist checked the expiry date of medicines as part of their final accuracy check. The pharmacy had two fridges and team members recorded the temperatures daily. Records showed that the temperature of the fridges was between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email or the company's intranet. These were printed and filed to show that action had been taken. The last filed drug alert seen during the inspection was from September 2023. Team members believed that alerts received after this had been actioned but could not show evidence of this. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally has suitable equipment to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had measuring cylinders which were either crown stamped or ISO marked and were marked to show which were for water and which were for liquid medicines. Some of the cylinders were not clean and this was highlighted to the RP to resolve. The pharmacy had triangles used to count tablets which had not been cleaned after use which was also highlighted.

The pharmacy had a mobile telephone for conversations that required privacy. It stored medicines awaiting collection away from public view to protect people's private information. Confidential information was secured on computers using passwords. And computer screens were positioned in the dispensary preventing unauthorised access to confidential information.

What do the summary findings for each principle mean?

Finding	Meaning
✓ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✓ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✓ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.